HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

SEX ASSIGNED AT BIRTH	SEX LISTED WITH HEALTH INSURANCE	WHAT IS YOUR GENDER IDENTITY?	PREFERRED PRONOUNS
❑ FEMALE ❑ MALE ❑ INTERSEX	❑ FEMALE ❑ MALE	❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____	❑She/Her ❑ Ze/Hir ❑He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY?	RACE	ADDITIONAL RACE	ETHNICITY
❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE			

FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH
		❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO

MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., stret, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

FULL NAME CONTACT #2	ADDRESS

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ❑ YES ❑ NO	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER